Adopted January 5, 1998 by the Managed Health Care Improvement Task Force

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

EXECUTIVE SUMMARY

I. INTRODUCTION

The financing and delivery of health care in California – indeed, throughout the nation – have undergone wrenching changes in the last few years. Public policy has not kept up with the fast-moving market. One of the most important market developments has been the very rapid growth in managed care. California leads in this trend, but the rest of the nation is not far behind.

"Managed care" has been broadly defined as "any system of health service payment or delivery arrangement where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both."[1] In California, managed care encompasses a wide array of payment and delivery systems, including different models of health maintenance organizations (HMOs), preferred provider organizations (PPOs), medical groups/independent practice associations (IPAs), integrated delivery systems, and many others.

The Legislature and the Governor created the California Managed Health Care Improvement Task Force through the passage of AB 2343 (Richter, Chapter 815, Statutes of 1996). The Task Force had two broad goals:

- *Descriptive*: AB 2343 called upon the Task Force to inform California's leaders about the current health care industry in California and the impact of managed care on the major measures of system performance (quality, access, and cost) as well as on specific segments of the industry or components of special concern to consumers. Findings pursuant to AB2343 can be found in various chapters throughout the Task Force report.

  Prescriptive: The Governor further charged the Task Force with advising California's leaders about the appropriate role of government, by reviewing and making recommendations regarding the state's oversight and regulatory role related to managed care.

The Task Force report includes four chapters of *Background Findings* and 12 additional chapters with 77 recommendations, grouped broadly among the themes of *Improving Regulation, Making Competition Work for Patients and Consumers*, and *Improving Quality of Care.*

For more information on the mission, composition, and operation of the Task Force, see the appendix to this Executive Summary.

According to the legislation, the number of Californians in Knox-Keene regulated health care service plans is large and expected to grow. Though the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code Section 1340 *et seq*.) contains many consumer protections, consumers and providers wanted to determine whether additional protections might be necessary. In addition, health plans, providers, health professions educators, and consumers wanted to determine whether and how different structures and payment mechanisms of the full range of managed care plans – whether or not regulated under the Knox-Keene Act – affect quality and cost, and how these entities can best be regulated.

[1] Physician Payment Review Commission, *Annual Report to Congress*, Washington, DC: 1996.

Commencing with its first meeting on April 22, 1997, the Task Force devoted substantial time to receiving and considering ideas raised in public testimony, both written and oral, and benefited greatly from the diverse views presented. The Task Force also conducted a substantial scientific public survey on the problems Californians are experiencing to inform its deliberations and recommendations.

The Task Force was made up of 30 people chosen to represent very divergent views about managed health care. Members were made up of, in equal numbers, health care service plans including at least one local initiative under contract with the State Department of Health Services as part of the two-plan model for Medi-Cal managed care and at least one disability insurer, employers who purchase health care, health care service plan enrollees, providers of health care (e.g., physicians and hospitals), and representatives from consumer groups. Despite the different perspectives represented, a majority of Task Force members agreed to the 77 multi-part recommendations (many with several sub-recommendations) outlined below.

The Task Force chose not to address some topics because they were considered outside the scope of the Task Force's charter. In particular, the Task Force did not think that it was within its mandate to engage in significant deliberations regarding the problems posed by the large and growing numbers of uninsured in California. The Task Force, however, strongly believes that the number of Californians without insurance needs to be addressed and that managed care has implications for the current systems that care for the uninsured. The Governor, Legislature, and private sector groups are strongly encouraged to continue to seek to address the issue of the large number of uninsured Californians.

As state, federal, and private purchasers increasingly contract with managed care plans, the financial stability of the safety net that traditionally serves the uninsured has become further eroded. Managed care's cost control mechanisms reduce the ability of safety net providers to shift costs from uninsured to insured patients. Trauma systems, emergency service networks, and the system of public health centers are most at risk in cities and counties throughout the state.

The Task Force agreed that it was not asked to, and therefore did not, comment on individual bills moving through the legislative process during the 1996 legislative session. In addition, the Task Force did not cover other important topics due to time constraints posed by the requirement to report back to the Governor and the Legislature by January 1998. The fact that the Task Force did not address a topic does not mean that members did not consider it to be important.

The Task Force did not have the time or resources to estimate the costs of its recommendations, either in isolation or taken together. However, the Task Force members were sensitive to the importance of making health care affordable and avoiding making cost-increasing recommendations, as premium increases would be likely to increase the ranks of the uninsured. The long-term costs and benefits of the Task Force recommendations should be evaluated and weighed before being implemented.

Due to its tight time schedule, the Task Force did not have time to prioritize its recommendations. Some are clearly more important than others, and some were more thoroughly researched than others. However, the relative importance attributed to different recommendations varies among members.

Implementing the Task Force's recommendations will require a combination of private sector and governmental actions. Some recommendations require legislation in order to be implemented. Others can be implemented through regulatory action, pursuant to existing statutory authority. Still others require private sector entities – sometimes alone and sometimes in combination with each other or with a government entity or entities – to follow the Task Force's recommendations.

II. FINDINGS AND RECOMMENDATIONS

** Indicates that a paper was required by AB 2343 (Chapter 815, Statutes of 1996).

The following sections summarize the major findings and recommendations of the Task Force. In an effort to be succinct, some unintended changes to their meaning may have occurred. As such, any interpretation of Task force findings and recommendations should be made, not from this summary, but rather from the source materials included in Volume I of the Task Force's main report. Numbers that appear in parentheses correspond to the number of a recommendation as adopted in a chapter of the Task Force report.

Certain common terms were used throughout this document and the Task Force report as a whole. They include the following:

- The intention of the Task Force is that "stakeholders" include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers in all the stakeholder groups recommended.

- The term "health plan" refers to any health insurance arrangements or health benefits financial intermediaries, including health maintenance organizations, preferred provider insurance, etc. The terms "Knox-Keene regulated plan" or "health care service plan" refer specifically to those health plans (i.e., health maintenance organizations) that are regulated under the Knox-Keene Health Care Service Plan Act of 1975.

- The term "state entity for regulation of managed care" refers to the Department of Corporations (DOC) or its successor. In the plural form, "state entity(ies) for regulation of managed care," the term refers to the DOC and the Department of Insurance (DOI) or their successor.

A. Improving Regulation

*1. Government Regulation and Oversight of Managed Health Care***

Health care has a special moral status and therefore a particular public interest. There are many important roles for government in the financing and regulation of health care and health insurance. The regulatory structure for health care in California was designed in the 1970s, and since that time the delivery of health care has changed significantly. Currently, operations of managed care organizations and of providers are overseen by many government and private entities. The Task Force believes that attention needs to focus on how changes can be implemented to improve the effectiveness of both private and public sector regulation.

The Task Force recommends the following with regard to streamlining regulatory oversight. A new state entity for regulation of managed health care should be created to regulate health care service plans currently regulated by the DOC and to phase-in the regulation of other entities over time, consistent with these recommendations (1.a-f). Appropriate health staff of the DOC will be transferred to the new regulatory entity (1a). Medical groups and other provider entities that bear significant risk should be directly regulated by the new state entity for solvency and quality. Within a year, the Governor and the Legislature should study and make a recommendation to the public as to the method for consolidated, direct regulation by this new entity of medical groups/IPAs and other provider entities in the state that are not currently directly regulated and who bear significant risk, on the basis of solvency and quality, to the extent they can be shown to be contributing to medical decisions (i.e., not coverage decisions determined contractually by an employer) (1b).

Within one year, the Governor and the Legislature should study the feasibility and benefit of consolidating the health care quality review functions of all state governmental agencies within the new entity (1c). Within two years, the Governor and the Legislature should consider folding into the new state entity the regulation of other health insurers providing insurance through indemnity, PPO and Exclusive Provider Organization (EPO) products currently regulated by the DOI (1d). Subsequently, the merits of folding into the new state entity other regulatory functions (e.g., those that regulate providers, clinicians, and medical facilities) should be examined. However, further consolidation should be phased-in in a manner that minimizes disruption of essential regulatory functions. Any proposed consolidation should weigh the potential benefit and possible detriment to the public and consider the impact on the stability of the organization (1e). Any health-related regulatory authority or related government entity not incorporated into this new state entity should develop enhanced electronic capabilities to share information and work together with other oversight entities (1f).

The new state entity for regulation of managed care's leadership should be either a *board* that would review and approve major policy and regulatory matters, with a majority appointed by the Governor and at least one member each appointed by the Senate and Assembly to staggered terms, with a full-time board Chairperson with day-to-day operating responsibility and authority, appointed by the Governor, or an *individual*, appointed by the Governor and confirmed by the Senate. The Chairperson or individual leader should have stature in the health services field and the ability to command respect and exercise strategic leadership. In either case, the leadership should have a sympathetic understanding of the problems of patients, families, and an understanding of the health care market (2a). In either case, the new state entity for regulation of managed care should establish an advisory committee, including leaders of other regulatory agencies as ex-officio/non-voting members, and stakeholders (2b).

Guiding principles for regulation by the state entity for regulation of managed care should include the following: be as efficient and streamlined as possible, be conducted in cooperation with other public and private bodies, recognize and expedite approval of beneficial innovations, and be fair, predictable and strictly enforce laws (3). The state entity for regulation of managed care should seek to streamline the oversight of health plans and providers, including the following: facilitating existing oversight of at-risk contractors with Knox-Keene plans (4), upon request of a provider group, overseeing one periodic solvency audit, for which the state entity for regulation of managed care may contract with independent, third-party organizations that meet standards established by the state entity for regulation of managed care and developed by a stakeholder working group (5), and upon request of a provider group, overseeing one quality audit, the cost of which would be shared by contracting plans, for which the state entity for regulation of managed care may contract with independent, qualified, third-party organizations that meet standards established by the state entity for regulation of managed care (6).

The Task Force endorses private sector data collection efforts in lieu of or in collaboration with state data collection, if there is full disclosure upon request of survey methods and results (7a), in a timely manner at no or low cost (7b), if collaboration does not limit or impede state determinations of which and how quality data should be monitored (7c), and results are valid (7d).

Government departments should coordinate activities and streamline information sharing with each other and with private sector quality measurement and accreditation bodies to develop standards and eliminate regulatory redundancy. Government departments should seek to avoid duplication of audits by auditors approved by the state entity for regulation of managed care and review plans only in those areas where the program differs from or exceeds Knox-Keene Act requirements (8).

To meet the challenges of accelerating industry change, the state entity for regulation of managed care should define and publish formal policies and procedures (9a), improve efficiency and consistency of decisions (9b), and designate timeframes for new product material modification approval and allow health care service plans to consider them approved if not acted upon within the specified timeframe, subject to prospective changes (9e). Legislation should be passed to allow plans to consolidate minor amendments into one annual filing (9c). An independent organization should evaluate the DOC budget augmentation (9d).

B. Making Competition Work for Patients and Consumers

2. Expanding Consumer Choice of Health Plans

Individual choice of health plans is very important for a variety of reasons, yet many Californians lack choice. Choices for individuals, especially sick individuals, may be limited due to problems of access. Among those who receive health coverage through their employer, the smaller the employer, the smaller the proportion that offers choices. Purchasing groups expand choice of plans, but their growth has been disappointing so far, and they are not available in many segments of the market.

The Task Force recommends the following: purchasers should offer choices of plans where possible, and the U.S. Congress and the California Legislature should seek ways to expand coverage and plan choice (1). The state should facilitate and encourage development of purchasing groups, and the DOC and the DOI should simplify their processes for purchasing group formation and recommend changes to the Legislature if necessary (2). Enact guaranteed issue, plan design disclosure, and premium rating limitations (currently in effect for the 2-50 market) in the 51-100 market (3). Convene a stakeholder working group to further examine increasing choice of providers on a cost neutral basis (4).

3. Minimizing Risk Avoidance Strategies

Capitated payments by purchasers to health plans and health plans to providers, if not adjusted for the medical needs of different patients, give plans and providers an incentive to avoid enrolling and developing expertise to care for the sickest individuals. Despite the use of some mechanisms to protect providers from financial exposure to high cost cases, “risk adjustment” is needed to eliminate incentives for skimming and to adjust for “adverse selection.”

The Task Force recommends the following payers conduct projects to risk adjust premiums in California: CalPERS, preferably with the University of California (UC) and the Pacific Business Group on Health (PBGH), within three years, depending on progress, concerns, and a recommendation reported in two years (1), Medi-Cal, depending on progress, concerns, and a recommendation reported in two years (2), Medicare as and when such projects are proposed (3), the Federal Employees Health Benefits Program (FEHBP) upon exploration (4), and perhaps purchasing groups within a reasonable timeframe upon implementation by CalPERS (5). When technically feasible, all health plans as a matter of licensure should be required to risk adjust payments to at-risk, contracting treating providers and in turn to at-risk, treating providers (6). Purchasers and foundations should make risk adjustment a high priority (7). The regulatory authority should oversee risk adjustment project efforts and report annually (8).

4. Standardizing Health Insurance Contracts

The inherent complexity of health insurance contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance, putting upward pressure on the price of health care coverage. Some standardization of health plan contracts within, but not necessarily among,

sponsored groups would increase understanding, reduce administrative costs, and facilitate consumer comparison of plans.

Task Force recommendations include the following: the state entity(ies) for regulation of managed care should be directed to adopt a pro-active policy toward standardized contracts and fast-track them through the regulatory process (1). The state entity(ies) for regulation of managed care, with the Major Risk Medical Insurance Board (MRMIB) and stakeholders, should be directed to develop and modify as appropriate, every two years, a set of five standard reference coverage contracts for all product types in the small group and individual markets. Health plans should be required to publish and provide upon request a comparison of any of their products with one of them (2).

The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group of stakeholders to develop and modify as appropriate, every two years, a standard outline and definitions for the evidence of coverage and other documents to facilitate comparison and should promulgate proposed rules for consideration and adoption of the working group's consensus (3).

5. New Quality Information Development

Providers are hampered in their ability to deliver excellent care by limited data to support evidence-based medicine. State efforts at data collection have been limited because each data element is included in statute, collected elements are confined to the hospital discharge abstract and reporting cycles are long. These limitations impede the timeliness and usefulness of resulting information. Further quality information is critical for comparing and choosing among health care options.

The Task Force recommends transition from a statutory to a regulatory approach to state data collection. The state should set broad data guidelines but give the state entity for regulation of managed care authority to approve data elements. The state entity(ies) for regulation of managed care should be authorized to convene an advisory body of stakeholders to evaluate specific data requests (1). The state entity(ies) for regulation of managed care should advance implementation of electronic medical records. The state entity(ies) for regulation of managed care should facilitate ongoing private and public sector efforts to develop standardized eligibility, enrollment, encounter, and clinical data. Components of electronic records should be phased-in by a target date of 2002-2004, depending on available resources. Strict provisions for patient confidentiality must be included. The President and the U.S. Congress should be responsible for establishing technical standards for uniform identifiers for patients and providers and uniform language and data definitions (2). Report comparative information by local geographic area where people are likely to seek and receive care. The state entity(ies) for regulation of managed care should facilitate ongoing private and public sector efforts to develop and distribute these data (3). The state entity(ies) for regulation of managed care, with the Office of Statewide Health Planning and Development (OSHPD) and the Department of Health Services (DHS), should create an expert panel to study and report by June 1, 1999 on ways to improve patient safety by reducing errors, adverse events and adverse outcomes (4).

C. Improving Quality of Care

6. Improving the Dispute Resolution Process

A fair and efficient dispute resolution process is an essential element of a well-functioning health care delivery system. The Task Force endorses essential elements of dispute resolution processes to ensure that they are fair, easily understood, timely and that they both resolve individual consumer's problems as efficiently as possible and provide information to improve the health care system.

The dispute resolution process should employ a collaborative process and build on existing standards and community resources (1). Because many of the dispute resolution standards are found in state law or regulation, the Task Force recommends, where state law does not necessarily apply, that the same standards should be adopted, including voluntarily where preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA, 29 USC Section 1001 *et seq*.), by employers in contracting with plans, and by the Department of Labor through regulation (2).

Consistent mandatory complaint process standards should be developed with stakeholders and adopted, including application to provider groups (3a), non-urgent and urgent timing requirements (3b), periods of limitation (3c), communication of processes and examples of appeals (3d), the ability of consumers to appear in person at plans' grievance hearings (3e), full and complete explanations of grievance and appeals decisions (3f), common standards for collecting information about complaints by health plans (3g), periodic public reports of complaints made to both health plans and the state entity(ies) for regulation of managed care (3h), and a single phone number for consumers to easily reach all state health regulatory entities (3i).

Consumers should receive a bill of rights and responsibilities on enrollment and adequate information upon a denial or grievable incident about next steps, explanations, and opportunity for a qualified, plan-paid second opinion (4). Private accreditation and quality audit standards should require plans to demonstrate adequate consumer assistance (5). Health plans should adopt best grievance practices (6).

Two pilot, independent external assistance or ombudsman programs should be authorized, and state funding should be secured, to assess how best to serve and educate all consumers about external assistance and to complement existing resources (7).

The state entity for regulation of managed care should be directed to establish and implement by January 1, 2000 an unbiased, expert-based, independent, third-party review process for grievances pertaining to medical necessity, appropriateness, and experimental treatments (8).

Health plans should be required to establish arbitration standards that provide for expeditious resolution, including rapid selection or default appointment of neutral arbitrators (9a), a written opinion to accompany an award, excluding confidential information, available to the public upon request (9b), and prohibit a plan that has engaged in willful misconduct from requiring a party to continue in arbitration (9c).

Stakeholders should assess the efficacy of dispute resolution mechanisms and evaluate them against principles including fairness and efficiency (10).

*7. Financial Incentives for Providers in Managed Care Plans***

Physicians and other health professionals are motivated by many incentives, including financial and non-financial incentives. All compensation arrangements contain incentives that may have positive and negative effects. Current federal and state laws prohibit arrangements that are an inducement to limit or

reduce necessary services to an individual enrollee, and federal law also requires physicians who are placed at substantial financial risk to have specified stop-loss protection.

The Task Force recommends the following improvements in disclosure of financial arrangements: health plan disclosure of scope and general methods and incentives paid to contracting provider groups, and health plan, provider group, and health practitioner disclosure of specific methods paid or received upon request (1)(3). The regulatory authority should conduct a pilot project to develop disclosure language for provider groups (2).

The Task Force further recommends that health plans and provider groups be prohibited from capitating individual practitioners for a substantial portion of the cost of referrals for that practitioner's patients (4a). Provide close scrutiny where incentives for individuals or small groups are tied to the substantial cost of referrals and where small groups are capitated for the substantial cost of referrals (4b); ensure the use of stop-loss, sufficient reserves, or other verifiable mechanisms for protecting against losses due to adverse selection for practitioners at "substantial financial risk" (4c).

Purchasing groups and accreditation organizations should use their leverage to influence positively compensation arrangements (5). An advisory group of stakeholders should examine compensation arrangements and recommend needed changes in regulatory oversight (6). The state entity for regulation of managed care should develop expertise in assessing compensation arrangements (7).

8. Physician-Patient Relationship**

The physician-patient relationship has been described as a covenant, fundamental to heath care delivery. The physician (or other provider)-patient relationship is multi-faceted. Physician-patient relationships have been shown to be beneficial to patients. Views of physician-patient relationships have evolved over time. The increased presence of third-party payors and the expansion of managed care have resulted in a decline in trust between physician and patient.

Task force recommendations include the following. Require health plans and medical group/IPAs to provide continuity with providers for chronically ill, acutely ill, and pregnant patients when they involuntarily change plans or when a provider is terminated for other than cause, through the course of treatment, up to a maximum of 90 days, or safe transfer. Require providers to accept plan payment rates and provide necessary information and records during transition (1a). Require treating providers to accept plan's out-of-network or PPO rate as payment, provide necessary information to the plan, and promptly transfer medical records (1b).

Require health plans to allow extended, prolonged, or permanent referrals to a specialist for enrollees with life-threatening, degenerative, or disabling conditions that require specialized care while maintaining coordination of services (2). Require disclosure of, and patient prior consent for, an appointment with a provider other than the one he or she was assigned or chose (3).

Require health care practitioners and hospitals to make known to consumers upon request, relevant experience, qualifications, and quality data as available, at every level of care, consistent with the informed consent process (4). Monitor federal reforms related to confidentiality of patient information and patient access and rights with respect to their medical records, and conform state law. Review state law to ensure confidentiality and medical records access and rights while allowing health plans, provider groups and providers to undertake activities required by law. Limit patient specific information disclosure to that which is necessary (5a). Prohibit health plans and their contractors from

requiring an enrollee, as a condition for securing health care services, to waive confidentiality protections for commercial uses (5b).

Numerous other recommendations that appear in other papers were incorporated in this paper by reference.

9. Consumer Information, Communication, and Involvement

Rapid changes in the health care delivery system have resulted in elevation of the importance of consumer information and involvement. The potential benefits of managed care, namely lower costs, higher quality of care and greater consumer satisfaction will be realized only in a system characterized by active and meaningful consumer participation. Consumers need unbiased, standardized information on health plans, medical groups/IPAs and providers to choose among plans and providers and to use the system to access quality health care. This is critically important to the functioning of the health care delivery system and to a well-functioning competitive market.

Information

The Task Force recommends that health plans be required to make available and accessible to consumers significant additional information, including the following: a "standard product description" to facilitate direct comparison of plans by consumers (1), up-to-date and specific information on provider access (4), information on referrals to specialty centers (2), and plans' and medical group/IPAs' written treatment guidelines or authorization criteria (3).

Further recommendations include the following: expand the DOC's grievance report to include information on the severity, urgency and outcomes of complaints (5); encourage initiatives to collect additional patient satisfaction and quality data at the provider group and plan levels (6); study the feasibility of developing a "Super Directory" of providers, hospitals, clinics and medical group/IPAs indicating which plans or groups they contract with (4); and encourage employers' inclusion of health benefits as a separate line item on employee pay stubs to increase employee awareness of the proportion of compensation represented by health benefits (7).

Involvement

The Task Force recommends the following: that the Knox-Keene Act be amended to require more substantial consumer involvement in health plans' governing bodies and/or member advisory committees (1); that purchasers use their bargaining power to ensure that health plans and contracting provider groups develop and utilize member involvement mechanisms (2); that accrediting bodies develop standards for member involvement and use of consumer feedback (3); that government, foundations, plans, provider groups and purchasers collaborate to fund expansion of organized systems of consumer involvement (4); and that the state entity(ies) for regulation of managed care incorporate member advisory committees into their oversight operations (5).

10. Improving the Delivery of Care and the Practice of Medicine

Today, health care practitioners and patients who agree on a course of necessary care may have that course altered either by delay or denial by an HMO or its utilization management designee. To improve this process and care outcomes, the Task Force recommends that plans incorporate provider pre-credentialing, practice guidelines, clinical pathways, retrospective review and outcomes-based data in utilization monitoring (1a). Plans should develop alternatives to Prior Authorization/Concurrent Review (PA/CR) based on statistically valid patterns of care and outcomes, or professional consensus (1b). Health care practitioners with an exemplary practice profile should care for patients with automatic plan approval for a defined scope of practice. A two-year probationary period may determine

eligibility for automatic approval. Plans may require providers to verify eligibility, coverage and approval for the setting in which the procedure is to be performed (1c). Plans should eliminate PA/CR for patients with catastrophic conditions for which there are accepted outcomes-based protocols (1d). Require a progress report by 2000 (1e). Denials of care must include a review by appropriately qualified, credentialed individuals (1f).

Ideally, the appropriate practice of medicine effectively integrates clinical judgment, diagnostic evaluations, surgery, therapies and drugs to form and inform clinical pathways, practice guidelines, and outcomes research. The drug formulary component of medical practice needs to be improved. The Task Force recommends the following: ensure that consumers should be informed of their rights to prescription drugs including periodic publication of formulary drug lists and development processes, access to exception processes by which non-formulary drugs can be obtained, continued receipt of a removed drug for an ongoing condition and periodic review of plan compliance by the state entity(ies) for regulation of managed care (2).

Benefit language has traditionally relied on vague terms with no precise meaning. Health plans have covered most things thought to be "medically necessary" or "appropriate" by providers or that met a "community standard." Task Force recommendations include creating a public/private expert panel to study changing the benefit language in health plan contracts to consider, among many issues, the needs of vulnerable populations and whether making existing contract language more precise will maximize quality outcomes while controlling costs (3a). The state entity(ies) for regulation of managed care should convene a clinical expert panel to determine best clinical practices and standards of care as well as when and how to reclassify therapies from experimental to proven treatments. This panel will also consider medical appropriateness in reference to treatment issues. This panel should also encourage all payors to identify and support experimental protocols in certain circumstances of life threatening or limiting illnesses (3b).

11. Vulnerable Populations

Serving the special needs of vulnerable populations creates a unique challenge for managed care organizations, be they health plans or provider organizations, contracting on a prepaid, capitated basis. Serving the needs of vulnerable populations requires special attention to having appropriately qualified staff and coordinating services. In virtually every area, the service provided to vulnerable populations serves as a critical measure of both managed care's strengths and weaknesses.

Managed care has great potential for better serving vulnerable beneficiaries by providing more effective management, coordinating multiple medical and social services, and exercising greater flexibility in providing the care that beneficiaries may require. However, the capacity of a plan to provide appropriate care for persons with chronic or complex illnesses and circumstances depends to a large extent on the way the plan is organized and financed. Some managed care arrangements may raise issues with respect to the following challenges that need to be addressed in serving these populations: (a) under-treating patients with chronic illness, (b) restrictions in seeking specialists, (c) lack of an expanded system of care and limited benefits definition, (d) discontinuity of treatment, (e) lengthy timeframes for authorization, (f) lack of consumer understanding, and (g) providers' failure to diagnose accurately.

The Task Force recognized that it could not consider the issues of vulnerable populations as distinct from the issues addressed in other areas of its report. For this reason, many recommendations that have importance and relevance to vulnerable populations appear in different sections of the Task Force report. The Task Force also endorsed the inclusion of vulnerable populations in decision-making, standard setting, and quality improvement initiatives recommended by the Task Force.

In addition to the relevant recommendations that appear in other sections (which are cross-referenced in the Vulnerable Populations section) the Task Force makes the following recommendations for all vulnerable populations: purchasers should explore the feasibility of identifying and tracking the vulnerable populations among their membership, and reporting technologically feasible performance outcomes for these populations (1); DHS and other entities should continue efforts to study and pilot initiatives to assess the feasibility of the integration of acute, chronic, and long-term care services, as well as linkages to social services in the community for all plans (2); and purchasers should encourage those plans they contract with to work towards credentialing and certifying medical group/IPAs and providers based on their knowledge, sensitivity, skills, and cultural competence to serve vulnerable populations (3).

In addition, the Task Force recommends the following for the state's Medi-Cal Populations: resources should be provided to DHS to prepare a periodic report for the legislature and interested public on the quality of and access to care for Medi-Cal consumers (4), the impact of Medi-Cal managed care on the capacity of the public health system and other safety-net entities to provide care for uninsured patients (5), the impact of Medi-Cal managed care on the capacity of public health entities to continue their work in population health including their capacity to track epidemiological trends and to do population-based health education (6).

12. Integration and Coordination of Care – Case Study on Women's Health

Managed care promises not only to contain health care costs, but also to improve efficiency and enhance health status and consumer satisfaction through a focus on prevention and better integration and coordination of care. While many managed care organizations have successfully contained costs and have increased availability and coverage of routine care and preventive services, they have gotten mixed reviews from a consumer satisfaction perspective and have largely failed to achieve many promised improvements over traditional indemnity plans, particularly in the area of coordination of services. Women's health provides a very powerful example of the failings, some of the successes and, most importantly, the potential of the managed care system to provide the benefits of integrated care.

The Task Force recommends the following: that managed care organizations work with purchasers and accrediting organizations to define survey questions that measure plans' success in coordinating members' care (1); that managed care organizations improve access and utilization of care by meeting members' needs for scheduling flexibility and confidentiality (2); that managed care organizations compensate community providers to whom members are referred or to whom members routinely self-refer for care they deliver (3); that, upon request, managed care organizations provide benefits and coverage information to all plan enrollees, not just the primary plan subscriber (4a); that managed care organizations' print materials explicitly indicate limitations on coverage of and referrals for reproductive health services (4b); that training programs for primary care providers incorporate the full range of primary health care needs, including women's reproductive primary care (5a); that managed care organizations ensure that primary care providers or provider teams made available to members are able to provide comprehensive primary care for both women and men (5b); that women be allowed direct access to their reproductive health care providers in a manner that permits and encourages coordination and integration of services (5c); and that the public and private sectors collaborate to develop and promote consistent standards for evidence-based, gender-specific practice guidelines (6).

D. Background Findings

13. Academic Medical Centers**

According to several leading authorities, too many specialists are being trained in California, as well as in other parts of the country. Leaders of California's academic medical centers (AMCs) should work together to develop an authoritative projection of physician personnel (and other health professionals) needs and a plan for adjusting educational programs to meet them.

An appraisal of the financial impact of managed care is made difficult by the fact that the financial data of AMCs are incomplete, uncertain, and not yet available for recent years during which change has been very rapid. However, in view of the increasingly competitive marketplace and pressures on reimbursement, the ability to cost-shift from private payors and Medicare is eroding. The cost of medical and health professional education will need to be clearly defined and appropriate financial support mechanisms to protect these public goods will need to be identified.

14. Health Industry Profile**

The Health Industry Profile presents the historical context of managed care and highlights key indicators of its tremendous and varied growth; provides a brief overview of the regulatory context of managed care in California; defines major industry terms, structures, and players; presents the primary challenges and objectives the health care industry faces in attempting to improve health care while continuing to contain costs; and discusses current industry trends.

15. Impact of Managed Care on Quality, Access and Cost**

While managed care has existed in California for decades, its recent and rapid growth has caused change in the areas of quality, access and cost.

Quality comparisons between health maintenance organizations and traditional indemnity plans have produced no overall "winner" in quality of care. Both consist of high, medium, and low quality organizations and providers.

Access is a multi-faceted issue. Lower HMO premiums keep coverage more affordable for more people. However, the flip-side of greater financial access is tighter restrictions on access to providers and services.

Driven by purchasers, competition, and threat of legislation, managed care has substantially slowed the rise in health insurance costs.

16. Public Perception and Experiences with Managed Care

The Task Force commissioned a public survey to complement the valuable testimony it received from individuals, to gain an understanding of whether the complaints received by California's Legislators are systemic, and to inform Task Force deliberations and recommendations regarding California's managed health care system. The Task Force Chairman and Vice Chairman worked closely with staff and outside experts in the design and question development of the survey instrument. Interviews were conducted by the Field Research Corporation and Helen Schauffler, Ph.D., University of California, Berkeley served as principal investigator. The survey consisted of three random samples: the general insured population, consumers who had problems or were dissatisfied with their experiences in their health plans, and consumers with serious or chronic illnesses.

Survey results indicated that, among people with all kinds of health insurance, not just HMOs, the majority of Californians are satisfied with both their current plan (76%) and with the California health

care system as it affects their families (61%). A majority (84%) also believes that at least minor changes are needed to make California's health care system work better.

A substantial proportion (42%) of insured Californians indicated that they had experienced at least one problem with their health insurance plan in the past 12 months. The nature of the problems and consumers' satisfaction with their resolution varied substantially. One in four Californians who were "very satisfied" with their health insurance plan reported experiencing a problem with their plan in the past year, indicating that some problems may have been minor or administrative. However, of those Californians who experienced problems, 1% reported that the difficulty led to a financial loss of at least $5000, 5% reported that the problem caused them to lose more than five days from work, 22% reported that the problem they had this year led to the worsening of their health condition, and 6% reported that the problem led to permanent disability. The survey indicated that the likelihood of having a problem varies significantly by the type of managed care plan in which the consumer is enrolled, the health status of the consumer, and the number of plans the consumer has to choose from at the time of enrollment.

The survey was substantially funded by grants from the California HealthCare Foundation, the Institute for Health Care Advancement and the Office of Statewide Health Planning and Development, with funding from the Robert Wood Johnson Foundation.

III. CONCLUSION

The findings and recommendations of the Task Force represent a set of centrist proposals that emerged from a very diverse body. Some will criticize them for going too far; others for not going far enough. That is inherent in compromise among opposed interests. The Task Force urges our leaders in California, in other states, and in the nation's capital to give these recommendations careful consideration.

Special thanks to the numerous individuals, experts, and organizational representatives who testified, or otherwise provided valuable input, to the Task Force.

I. MEMBERSHIP

The Managed Health Care Improvement Task Force (Task Force) convened its first meeting on April 22, 1997 as a result of the passage of AB 2343 (Richter, Chapter 815, Statutes of 1996).[2] The Task Force was comprised of 30 members (20 gubernatorial appointees, five Senate Rules appointees and five members appointed by the Assembly Speaker). In addition, there were seven, non-voting Ex Officio members (five gubernatorial appointments and two members appointed by the Senate Rules Committee).

As prescribed in AB 2343, the Task Force membership was comprised of equal representation from the following groups:

(1) Health care service plans, including at least one local initiative under contract with the State Department of Health Services as part of the two-plan model for Medi-Cal managed care, and at least one disability insurer (Plan).

(2) Employers who purchase health care (Purchaser).

(3) Health care service plan enrollees (Enrollee).

(4) Providers of health care (Provider).

(5) Representatives for consumer groups (Consumer).

Appointed Voting Members:

NAME	EMPLOYMENT	APPOINTEE	APPOINTMENT CATEGORY
Bernard S. Alpert, M.D.	Bernard S. Alpert, M.D., Inc.	Gubernatorial	Provider
Rodney Armstead, M.D.	United Health Plan	Senate	Plan
Rebecca L. Bowne	Continental Northern America	Gubernatorial	Plan
Donna H. Conom, M.D.	Pacific Vista Neonatology Association	Gubernatorial	Provider
Barbara L. Decker	Southern California Edison	Gubernatorial	Purchaser
Alain C. Enthoven, Ph.D.	Stanford University	Gubernatorial	Enrollee
Nancy Farber	Washington Hospital	Senate	Provider
Jeanne Finberg	Consumers Union	Senate	Consumer
Hon. Martin Gallegos, D.C.	California Assemblyman	Assembly	Provider
Bradley Gilbert, M.D.	Inland Empire Health Plan	Gubernatorial	Plan
Diane Griffiths	California Assembly Speaker's Office	Assembly	Enrollee
Terry Hartshorn	PacifiCare Health Systems	Gubernatorial	Provider
William Hauck	California Business Roundtable	Gubernatorial	Enrollee
Mark Hiepler	Law Firm of Hiepler & Hiepler	Senate	Purchaser
Michael Karpf, M.D.	UCLA Medical Director	Gubernatorial	Enrollee

[2] A copy of AB 2343 (Chapter 815, Statutes of 1996) is included as an appendix to the Main Report.

NAME	EMPLOYMENT	APPOINTEE	APPOINTMENT CATEGORY
Clark E. Kerr	21st Century Consumer	Gubernatorial	Consumer
Peter V. Lee	Center for Health Care Rights	Gubernatorial	Consumer
J.D. Northway, M.D	Valley Childern's Hospital	Assembly	Purchaser
Maryann O'Sullivan	Health Access Foundation	Assembly	Consumer
John A. Pérez	UFCW Region 8 States Council	Senate	Enrollee
John A. Ramey	California Advantage, Inc.	Gubernatorial	Enrollee
Anthony Rodgers	LA Care Health Plan	Assembly	Plan
Helen Rodriguez-Trias, M.D.	Western Consortium/Public Health	Gubernatorial	Consumer
Les Schlaegel*	Bank of America	Gubernatorial	Purchaser
Ellen B. Severoni, R.N.	California Health Decisions	Gubernatorial	Consumer
Bruce W. Spurlock, M.D.	California Healthcare Association	Gubernatorial	Provider
David J. Tirapelle	California Department of Personnel Administration	Gubernatorial	Purchaser
Ronald A. Williams	Blue Cross of California	Gubernatorial	Plan
Allan S. Zaremberg	California Chamber of Commerce	Gubernatorial	Purchaser
Steven R. Zatkin	Kaiser Foundation	Gubernatorial	Plan

Appointed Ex-Officio Members:

NAME	EMPLOYMENT	APPOINTEE
Kim Belshé	Director, Department of Health Services	Gubernatorial
Marjorie Berte	Director, Department of Consumer Affairs	Gubernatorial
Keith Bishop	Commissioner, Department of Corporations	Gubernatorial
Charles Quakenbush	California Insurance Commissioner	Gubernatorial
Michael Shapiro	Consultant, Senate Insurance Committee	Senate
David Werdegar, MD	Director, Office of Statewide Health Planning and Development	Gubernatorial
Senator Herschel Rosenthal	California Senator	Senate

The Task Force was chaired by gubernatorial appointee, Professor Alain C. Enthoven, an economist and a nationally recognized expert in the field of health policy as well as a professor of public and private management at the Graduate School of Business, and professor of health research at the School of Medicine at Stanford University.

* Les Schlaegel replaced Kathryn Murrell who resigned upon her retirement.

II. STAFF:

California State Staff:
Philip Romero, Executive Director; Alice M. Singh, Deputy Director for Legislation and Operations; Hattie R. Skubik, Deputy Director for Policy and Research; Terri Shaw, Jennifer Tachera, Stephanie Kauss, Enrique Ramirez, Spencer Mendez, and Lawrence Ahn.

Stanford University Staff:
Sara J. Singer, Director/Editor; Carol Vorhaus, Margaret Laws, Megan Jenks, Aimee Jungman, Vicky Keston, Matt Solomon, Susan Boyle, Brian Haas, Meg Holland, and Tom Lee.

III. CHARGE

AB 2343 directed the Task Force to research and report on the following by January 1998:

(1) The picture of health care service plans, as it stands in California today, including, but not limited to the different types of health care service plans, how they are regulated, how they are structured, how they operate, the trends and changes in health care delivery, and how these changes have affected the health care economy, academic medical centers, and health professions education.

(2) Whether the goals of managed care provided by health care service plans are being satisfied, including the goals of controlling costs and improving quality and access to care.

(3) A comparison of the effects of provider financial incentives on the delivery of health care in health care service plans, other managed care plans, and fee-for-service settings.

(4) The effect of managed care on the patient-physician relationship, if any.

(5) The effect of other managed care plans on academic medical centers and health professions education.

At its opening meeting, Governor Wilson further charged the Task Force with reviewing and making recommendations regarding the State's oversight and regulatory role related to managed care. Specifically, the Governor stated, "We're at a critical juncture in shaping the future of California's health care system. It's not enough that California has been a leader in managed care…improving our health system by enhancing market incentives. We need to move forward – further streamlining and improving government's oversight and regulation, while preserving managed care's best features: coordinated teams of highly skilled professionals delivering cost-efficient, patient-sensitive care based on the best clinical information science has to offer…" In addition, Governor Wilson charged the Task Force with bringing "…a comprehensive, global perspective to the vexing issues facing us as we work as a community to bring excellent health care to our citizens…without stifling the research and development on which the world relies to advance medical care."

To ease public access of Task Force documentation and prepared materials, Task Force staff worked in conjunction with the staff at OSHPD to develop and maintain a Task Force Web page with the following address www.chipp.cahwnet.gov/mctf/front.htm.

IV. MEETINGS AND HEARINGS

To assist the Task Force in accomplishing its charges, the Task Force convened a series of statewide public meetings and hearings from April 1997 through January 1998. Specifically, the Task Force conducted 12 business meetings, five Study Sessions and six public hearings in accordance with the Bagley Keene Open Meetings Act. Adopted meeting minutes and study session and public hearing notes are included in the Appendices of this report.